

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

03844

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03834

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. LENGTH OF STAY IN 1b <b>13-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery Road near Landing Road</b>		d. STREET ADDRESS <b>Kynes Lane</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MICHAEL HARRY BUJANOWSKI</b>		4. DATE OF DEATH Month Day Year <b>March 19, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1899</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi Driver</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>Baltimore, Md</b>	
13. FATHER'S NAME <b>John Bujanowski</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-3934</b>	
17. INFORMANT <b>Mrs. Hazel Bujanowski</b>		Address <b>Kynes Lane, Elkridge, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardio vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>3 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>George E. Burgtorf</b> M.D.		22. DATE SIGNED <b>3-19-1966</b>	
EXAMINER'S NAME (Type) <b>George E. Burgtorf M D</b>		42 Church Road, Ellicott City, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-22-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>	23d. LOCATION (City or Town) (County) (State) <b>Elkridge, Md</b>
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18250

18250

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

03845

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03835

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenwood</b> c. LENGTH OF STAY IN 1b <b>Glenwood</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Roxbury Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenwood</b> d. STREET ADDRESS <b>Roxbury Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JON BLISS de Witt</b> First Middle Last 4. DATE OF DEATH <b>March 10, 1966</b> Month Day Year				5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>Mar. 2, 1949</b> 9. AGE (In years last birthday) <b>17</b> yrs. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Canton, Ohio</b>	
13. FATHER'S NAME <b>Wallace de Witt Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Jean Conner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Wallace de Witt Jr. Glenwood, Md</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound, penetrating, head</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>145 days</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED <b>3/10/66</b>			
ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D. EXAMINER'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>44 Chuck Rd Ellicott City, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-14-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION (City or Town) (County) (State) <b>Glenwood, Md</b>	
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b> ADDRESS				25a. REC'D BY REGISTRAR <b>MAR 14 1966</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

600

23



Bullet wound, penetration, head

x x

x

James S. Stewart

x  
Blind Creek  
March 14, 1914

Page 1 of 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03836

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simons Rest Home</b>				d. STREET ADDRESS <b>13 - 1</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>CLARK</b> Last <b>DORSEY</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>28</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1886</b>		9. AGE (In years last birthday) <b>79</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At. Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wm. T. Clark of T</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Dorsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Arthur Eyre, Highland, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>20 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>2/25, 1966</b> to <b>3/20, 1966</b> , that I last saw the deceased alive on <b>3/27, 1966</b> , and that death occurred at <b>20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D.							
PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, MD, CLACKSVILLE, MD</b> <b>3/28/66</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-31-1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Highland, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR <b>MAR 30 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03847

03837

1. PLACE OF DEATH a. COUNTY <b>HOWARD COUNTY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HOWARD COUNTY</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKRIDGE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SHARFFER NURSING HOME</b>				d. STREET ADDRESS <b>43 HUNT CLUB ROAD 21227</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HAROLD BRACE FISHER</b>				4. DATE OF DEATH Month Day Year <b>MARCH 29, 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 30, 1884</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DEPUTY SHERIFF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>SPRINGFIELD, MASSACHUSETTS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WILLIAM E. FISHER</b>			
14. MOTHER'S MAIDEN NAME <b>JENNIE R. GRANT</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>220-44-2369</b>		17. INFORMANT Address <b>MR. HAROLD W. FISHER, 43 HUNT CLUB ROAD #27</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Cardiac Failure</b> DUE TO (b) <b>A-S-CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia Post-Cerebrovascular Accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/15, 1965</b> to <b>3/25, 1966</b> that (I) (we) last saw the deceased alive on <b>3/29, 1966</b> , and that death occurred at <b>12:15 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>J. N. Frederick</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. N. Frederick</b>				22d. ADDRESS <b>1311 Lanes Ave. Balt. Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-1-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SPRINGFIELD CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SPRINGFIELD, MASSACHUSETTS</b>	
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE 21229</b>				25a. REC'D BY REGISTRAR <b>APR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



18250

18251





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

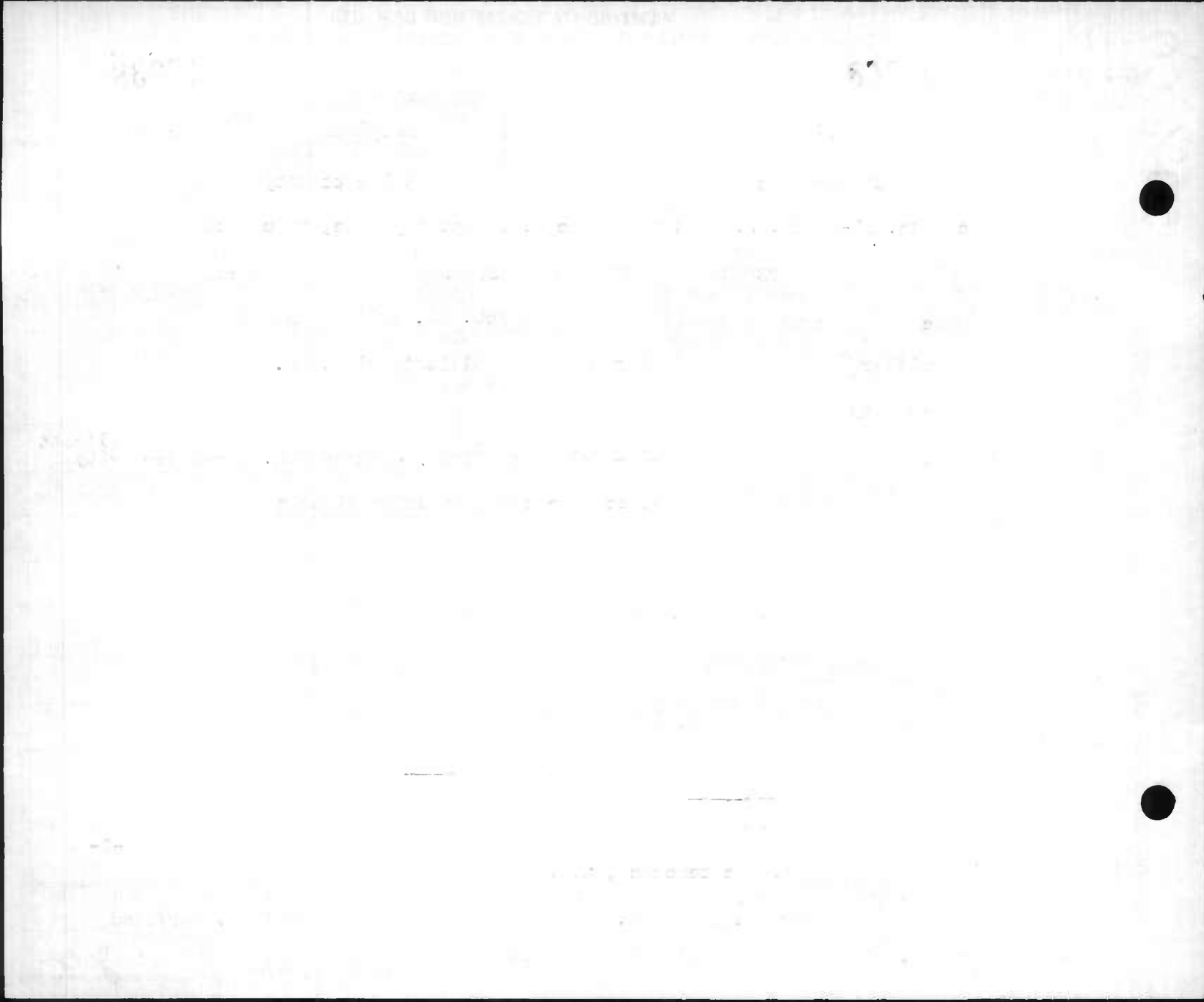
03848

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03838

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
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1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>		c. LENGTH OF STAY IN 1b <b>Ellicott City</b> 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>New Rte. 32-1 blk. S. of Clarksville, M.D.</b>		d. STREET ADDRESS <b>Bethany Lane, Pine Orchard</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>GILBERT</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1925</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months <b>41</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Ellicott City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ellicott City</b>	
13. FATHER'S NAME <b>Otis Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Hattie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-8323</b>	
17. INFORMANT <b>Mrs Gladys Johnson</b>		Address <b>Rte. 2 Box 355 Ellicott City</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. Breitenecker, M.D.</b>		22. DATE SIGNED <b>3-2-66</b>	
EXAMINER'S NAME (Type) <b>R. Breitenecker, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 5, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>	23d. LOCATION (City or Town) (County) (State) <b>Clarksville, Maryland</b>
24. FUNERAL DIRECTOR <b>Harry H. Witzke</b>		ADDRESS <b>321 Columbia Pike Ellicott City</b>	
25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03849 CERTIFICATE OF DEATH 03839

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4 Hale Haven Drive</u>		d. STREET ADDRESS <u>4 Hale Haven Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN GODWIN MASSEY</u>		4. DATE OF DEATH Month Day Year <u>Mar. 27, 1966</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1919</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pari Mutual</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race Track</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Lena Pease</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-01-9454</u>	
17. INFORMANT <u>Mrs. Mary Katherine Massey, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>66</u> , to <u>3/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> 19 <u>66</u> , and that death occurred at <u>      </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John C. Pease</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John C. Pease</u>		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-30-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MAR 30 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

1 (M)

03850

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03840

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dorsey</b> c. LENGTH OF STAY IN 1b <b>X</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cedar Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dorsey</b> d. STREET ADDRESS <b>Cedar Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>O.</b> Last <b>POWELL SR.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1889</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Signalman (Ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Powell</b>		14. MOTHER'S MAIDEN NAME <b>Emma Easton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705/12/3669</b>	
17. INFORMANT <b>Mrs. Ida M. Powell</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma Upper lobe left lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1st</b> , 19 <b>65</b> , to <b>Mar. 14th</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>66</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank Shipley Sr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Frank Shipley Sr. MD</b>		22d. ADDRESS <b>Savage, Md.</b>	
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 14, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Elkridge, RFD Md.</b>	
24. FUNERAL DIRECTOR <b>R.V. SINGLETON</b>		ADDRESS <b>GLEN BURNIE, MD.</b>	
25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

04860

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

03851

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

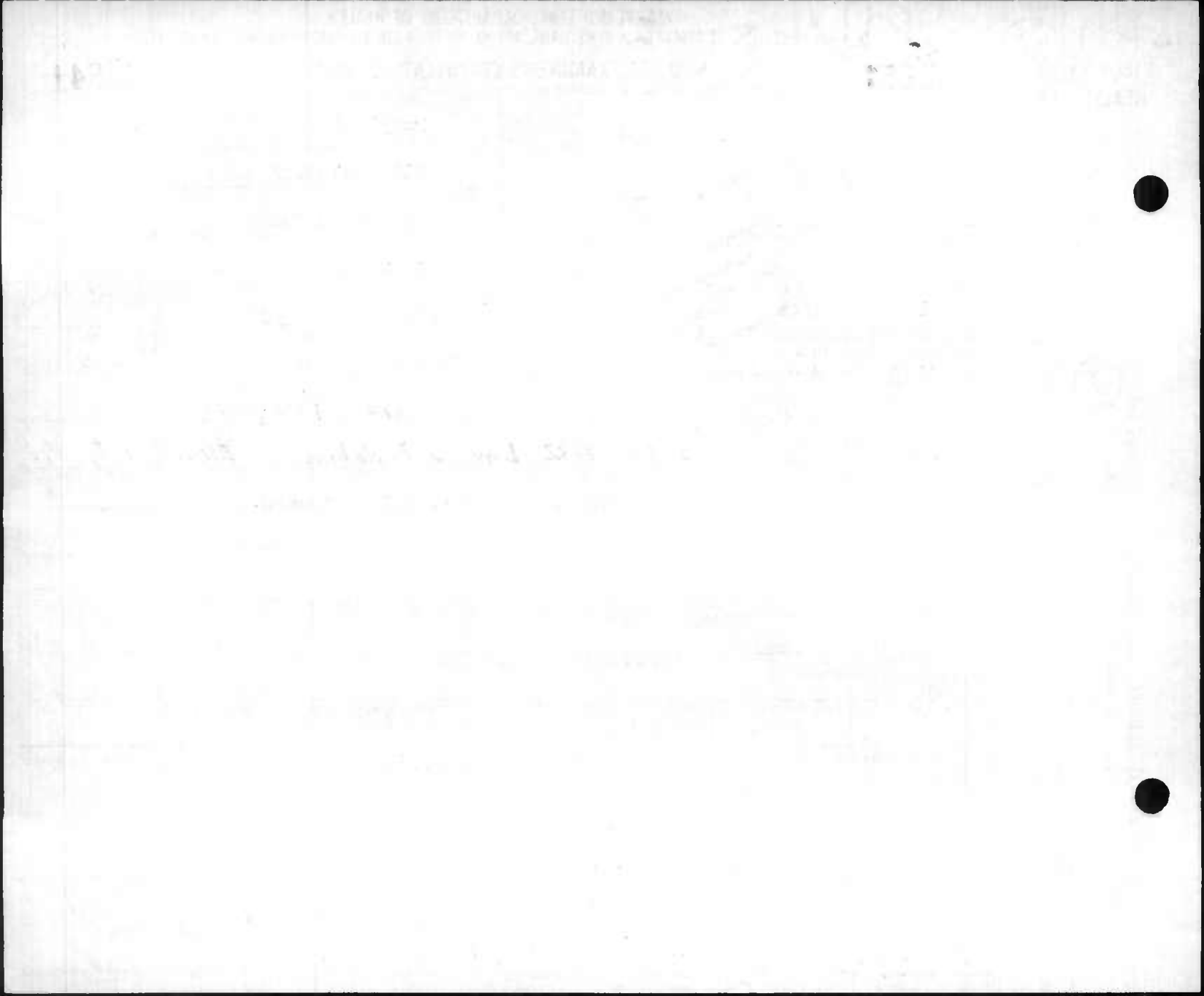
03841

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>Ellicott City</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>108 Club, Route 108</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>320 Church Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>HERBERT</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/1/1910</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>13</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAR TENDER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Oella Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Yingling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-6132</b>	
17. INFORMANT <b>LAVINA F. ROBINSON</b>		Address <b>Ellicott city Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.		22. DATE SIGNED <b>3/3/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/7/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>	23d. LOCATION (City or Town) (County) (State) <b>Howard Co. Md.</b>
24. FUNERAL DIRECTOR <b>E. S. Mac Nabb</b>		ADDRESS <b>Balto 21228 Md</b>	
25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03852

03842

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Howard</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 246 Washington Blvd</b>		d. STREET ADDRESS <b>Box 246 Washington Blvd</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Laura Burton Starling</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>20</b> Year <b>1966</b>	
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>September 21, 1881</b>
<b>9. AGE</b> (In years last birthday) <b>84 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>13</b> Days <b>1</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Mount Airy, N. Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>George W. Jones</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>no</b>	
<b>17. INFORMANT</b> <b>Ethel Mae Day Box 246 Wash. Blvd, Elkridge, Md.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b> 331X DUE TO <b>arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>more</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>3</b> p.m. <b>20</b> 19 <b>65</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg. etc.) <b>3/20/65</b>	<b>20f. (City or town) (County) (State)</b> <b>3/20/66</b>
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>3/19/65</b> to <b>3/20/66</b> , that (I) (we) last saw the deceased alive on <b>3/19/65</b> and that death occurred at <b>9 a.m.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Frank E. Shipley</b> M.D.		<b>22b. DATE SIGNED</b> <b>March 22, 1966</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Frank E. Shipley</b>		<b>22d. ADDRESS</b> <b>Savage, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>March 22, 1966</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Union Cemetery, Mt. Airy</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Surry Co., N. C.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>DeWitt Donaldson, Laurel, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 22 1966</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

03248

CERTIFICATE OF DEATH

03248

DATE OF DEATH

1944

PLACE OF DEATH

AT HOME

CAUSE OF DEATH

HEART DISEASE

AGE AT DEATH

SEX

MALE

DATE OF BIRTH

1900

1900

1900

1900

1900

1900

1900

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1900

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1900

1900

## CERTIFICATE OF DEATH

Reg. Dist. No.

03853

03843

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WHITNEY THARIN</u>				4. DATE OF DEATH Month Day Year <u>March 25, 1966</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1908</u>	9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Journalist</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick, Ga.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Daniel C. Tharin</u>				14. MOTHER'S MAIDEN NAME <u>Mabelle Whitney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-32-3849</u>		17. INFORMANT Address <u>Mrs. Elizabeth Tharin, Highland, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthenia &amp; chronic brain syndrome from stroke in 1954</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 11</u> , 19 <u>54</u> , to <u>March 25</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>66</u> , and that death occurred at <u>9:00P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u> <u>Clarksville, Maryland</u> <u>3-26-66</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-27-1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 29 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03854

03844

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>		c. LENGTH OF STAY IN 1b <b>Clarksville</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>		d. STREET ADDRESS <b>102 Thompson Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>102 Thompson Drive</b>		3. NAME OF DECEASED (Type or print) <b>JOSEPHINE J. WARFIELD</b>		4. DATE OF DEATH <b>March 3, 1966</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 24, 1894</b>		9. AGE (In years) <b>71</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Guilford, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George M. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Ione Johnson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>							
17. INFORMANT <b>William C. Warfield, 102 Thompson Drive.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Thomas F. Herbert</b>		M.O. <b>Thomas F. Herbert M.D. Church Road. Ellicott City, Md.</b>		22. DATE SIGNED <b>3-4-1966</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-6-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		23d. LOCATION (City or Town) (County) (State) <b>Ellicott City, Md</b>		24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>	

James S. Stewart



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

03855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03845

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN lb <b>30-4</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Patapsco State Park near Rt. 40</b>				d. STREET ADDRESS <b>5008 Pimlico Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR SIDNEY WAXMAN</b>		4. DATE OF DEATH <b>March 20, 1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1913</b>		9. AGE (In years lost birthday) yrs. <b>52</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engr</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Norfolk, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? LOUIS</b>		14. MOTHER'S MAIDEN NAME <b>Rose ?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-63-1910</b>	
17. INFORMANT <b>Shirley Waxman</b>		Address <b>5008 Pimlico Road. Baltimore</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <b>Bronchial Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>	
22. DATE SIGNED <b>3-21-1966</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bnai Israel</b>	
23d. LOCATION (City or Town) (County) (State) <b>Balto Md</b>		24. FUNERAL DIRECTOR <b>Sylvan Lewis &amp; Son</b>		25a. REC'D BY REGISTRAR <b>MAR 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert

General DeLynn

General DeLynn

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edkridge</u>		c. LENGTH OF STAY IN 1b <u>13 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edkridge Md.</u>		<u>13-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2015 London Ave</u>				d. STREET ADDRESS <u>2015 London Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>James</u>		Middle <u>V</u>		Last <u>Weigman Jr.</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/16/1900</u>	
9. AGE (in years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		4. DATE OF DEATH <u>Mar 22 1966</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rigging Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles C. Weigman</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hoffman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs Helen Weigman</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell Carcinoma</u> <u>163x</u> DUE TO (b) <u>Left Lung</u> DUE TO (c) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>4 mo from diagnosis</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1965</u> , to <u>Mar 1966</u> , that (I) (we) last saw the deceased alive on <u>Mar 22 1966</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>B B Brumbaugh</u>						22b. DATE SIGNED <u>3/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>				22d. ADDRESS <u>3609 main st Edkridge</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Windsorbridge Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Edkridge Md.</u>	
24. FUNERAL DIRECTOR <u>John J. Cowan &amp; Son Inc. Hollins</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 24 1966</u>			
				25b. REGISTRAR'S SIGNATURE			

105240

105240



MAR 31 1963  
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03857					03847						
1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fulton</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Simons Rest Home</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton Simpsonville 13-1</b> d. STREET ADDRESS <b>Simons Rest Home</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>THERESA WEYRICH</b>			4. DATE OF DEATH <b>March 23, 1966</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Nov. 29, 1872</b>			9. AGE (In years last birthday) <b>93</b> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Not known</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>Otto f. Weyrich</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth A Germrodt</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Simons Rest Home records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>446X</b> DUE TO <b>NEPHROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>NEPHROSCLEROSIS</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 mos. 10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA RT. BREAST (surgery 10 yrs ago)</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <b>1/7</b> , 19 <b>56</b> , to <b>3/23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/23</b> 19 <b>66</b> , and that death occurred at <b>1:30</b> P.M. from the causes and on the date stated above.			22a. SIGNATURE <b>Charles S. Whitaker, M.D.</b>		
22b. DATE SIGNED <b>3/23/66</b>			22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>			22d. ADDRESS <b>CLARKSVILLE, MD.</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-25-1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>			23d. LOCATION (City, town or county) (State) <b>Highland, Md</b>		
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>			25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03848

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Dayton</b> c. LENGTH OF STAY IN b <b>15 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Howard Road</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural - Dayton</b> d. STREET ADDRESS <b>Howard Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Dorothy</b> Last <b>Whitehurst</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/25/93</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretarial</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USGov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John McCuistion</b>		14. MOTHER'S MAIDEN NAME <b>Ann Barham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Ben Whitehurst (husband)</b>		Address <b>Dayton, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>instant.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D.		22. DATE SIGNED <b>3-4-66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>		Address (Street, city, town, or county) <b>Clarksville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3-7-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>J. William Lee &amp; Sons.</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03859

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03849

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Waterloo</b> c. LENGTH OF STAY IN lb <b>Surgoinsville</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US 1 between Laurel &amp; Waterloo</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <del>XXX</del> <b>Tennessee</b> b. COUNTY <b>Hawkins</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Surgoinsville</b> d. STREET ADDRESS <b>79-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS E. WILLIAMS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/16/1900</b>
9. AGE (In years less birthday) yrs. <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>	
11. BIRTHPLACE (State or foreign country) <b>Unicos Co. Tenn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Williams</b>		14. MOTHER'S MAIDEN NAME <b>Roda Moore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT Address <b>Colboch-Price Funeral Home Rogersville, Tenn</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> <b>8124</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pedestrian struck by auto</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>pedestrian struck by auto</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:15 p.m. 3 19 19 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <b>hiway</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hiway</b>		20f. (City or town) (County) (State) <b>Rt. 1 Howard Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>3/20/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/23/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Family Plot Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rogersville, Tenn</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202</b>		25a. REC'D BY REGISTRAR <b>MAR 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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